The PREVENTION CONNECTION
NEWSLETTER

Is Speed Still a Factor in Montana?

By Dave Peshek, Administrator, Montana Chemical Dependency Center

No, we're not talking about how fast our vehicles are driving on our roadways. We're talking about another illegal activity that ruins the lives of Montanans in a very different, but nonetheless deadly, fashion. We're talking about speed in another form—methamphetamine.

Evidence would suggest that there has not been any significant slowing down of speed—it continues to be widely manufactured and used, rapidly addictive and devastatingly destructive. The costs associated with methamphetamine treatment, coupled with meth lab cleanup, additional need for law enforcement, broken families, unemployment, and the more frequent and costly health issues common to addicts and their children add up to a monumental impact on Montana's citizens.

> **"I was hooked from the start. I felt like the devil stole my soul. I've been chasing that feeling that I got that very first time. People don't understand how powerful this drug is. It will turn your life upside down before you even realize it; it's a very deceiving drug."**
>
> ***– a methamphetamine patient at MCDC***

Over the past five years, treatment data from the Montana Chemical Dependency Center (MCDC) indicates that the percentage of the population receiving inpatient treatment at this facility has remained relatively stable—approximately one-third of the patients treated in a given year are meth addicts. That is one-third of a total of approximately 800-900 patients. There tends to be a slightly higher percentage of female meth addicts than male addicts in treatment. The preferred route of use for both men and women is injection or IV use. This method also carries with it an increased likelihood of being infected with HIV or Hepatitis C. These infections are often coupled with other physical and psychological problems that manifest from use.

Given the necessity of significant lifestyle changes associated with recovery from any substance, the life-style changes required to maintain recovery from a highly addictive substance such as methamphetamine are truly monumental. Multiple relapses begin to take a powerful toll on the individual, a fact that becomes increasingly obvious if the individual enters treatment multiple times. We often see the ravages of this drug on the brain as evidenced by the emergence and progression of psychiatric disorders coupled with progressive physiological complications. Treatment becomes more complex, more expensive, takes longer and requires a wider mix of professional staff to deal with multiple issues in addition to the addiction.

To quote another patient at Montana Chemical Dependency Center: *"Someone else doesn't have to ruin their whole life over this* (meth); *I've already done it for them."* This statement, unfortunately, will not likely keep anyone from trying this highly addictive and devastating substance—but it should!

Methamphetamine in Montana

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
Web Site: www.state.mt.us/prc

Director
Vicki Turner
(406) 444-5986
vturner@state.mt.us

Guylaine Gelinas
Administrative Support
(406) 444-9772

Mary Asbach
VISTA Leader
(406) 444-9655
masbach@state.mt.us

Kelly Backhaus
VISTA Leader
(406) 444-3925
kbackhaus@state.mt.us

Ryan Smart
Program Specialist
(406) 444-9654
rsmart@state.mt.us

The Vicki Column

We had intended to dedicate this issue to "treatment." Then we began discussing the articles we'd need, and realized methamphetamine abuse has become so prevalent in Montana that we'd need an entire issue to discuss this drug *alone*.

There are a few things we know about young adults. Teens are at a developmental stage in which they need to take risks, make their own decisions and begin taking control over their lives. They resist being labeled. At the same time, most teens view their chemical use as normative social behavior. They do *not* believe it is problematic and that it *is* something they will outgrow. These developmental characteristics, when put in context with methamphetamine, are particularly dangerous.

Methamphetamine is a scourge on our communities. It is a deadly drug that is reportedly easy to manufacture. It is highly addictive and virulently physically, emotionally, intellectually, financially and spiritually destructive. With this issue, we've attempted to provide a multi-faceted look at the effects of this drug on Montana, but we know that we've only been able to explore the tip of the iceberg.

Viruses all have a point of contagion. After the period of contagion has passed, there is no longer much threat of passing the virus on. If we look at addiction as if it were a virus, the point of contagion comes during the early stages of use, before the negative effects begin to show. No one is going to look at a methamphetamine addict and *aspire* to having their teeth turn black and fall out, lose the ability to feel joy or hold a coherent conversation. No one would *choose* to begin viewing the world through distorting lenses coloring everything with fear, anger and paranoia. No one would choose to age decades in the space of months, to shed beauty, health and vitality like old clothes.

The brief time before the consequences of this drug become apparent is when the virus spreads. That's what makes prevention imperative. One writer in this issue compared methamphetamine to a band of gunslingers taking over a town in the Old West. In order to fight the gunslingers, we must have a good working knowledge of what this drug is and how it looks. We need to understand what it does to people of all ages and to our communities. We hope this issue will begin to provide those tools.

Vicki

Notes From the Edge

Family Reunion

By Ron Clem

Tickets purchased, accommodations confirmed, a journey of uncertainty, everything to gain, a family to heal.

As we walked down the jetway at Glacier Park International Airport, thoughts, memories and anxieties seemed to mesh all into one. Our entire family has been affected by our daughter's use of methamphetamine and her attempt at suicide. It's been a year since we have all been together. We escorted Carren to a residential rehab facility over eight months ago. The months prior to that she had been living on the streets. Alicia fled home for college at Bozeman. Scott was still at home, overwhelmed and struggling. Karyl and I were left wondering how it had all come to pass.

Seven months ago, Alicia, embarrassed by her younger sister's actions, frustrated over her own life events, and angry with us for our perceived failure as parents, stood screaming and crying, "*I am going to college, trying to make something out of my life. All the money you are wasting on Carren should be for my college. She is just trash, it will all be for nothing.*"

Scott, currently in his junior year of high school, scared straight as a result of the consequences Carren has suffered was still trying to make sense of it all. Carren—his older sister, his long ago sandbox buddy, sledding partner and confidant—was gone. Kids at school berated him by recounting her actions. He has been hurt deeply, his life shadowed by our efforts to save his sister Carren.

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The Prevention Connection

Sherrie Downing
Editor
(406) 443-0580
Fax: (406) 443-0869
E-mail: DowningSL@attbi.com
www.sherriedowning.com

Karen von Arx Smock
KD Graphics
Freelance Design & Production
Phone/fax: (507) 894-6342
E-mail: kdgrafix@acegroup.cc

Family Reunion

Continued from cover

Karyl is quiet, praying for a miracle, the eternal mother, an only child herself, not understanding the constant bickering between siblings. She believes the chance for reconciliation will only come from God's intervention.

For me, the flight created conflicts and concerns. With the majority of my family close at hand and Carren safe, a great distance away, I felt I needed to put all my business and personal effects in order. My business supports so many and I want to ensure it continues. Most important, though, are Carren's well-being and provisions for her to complete the program.

The flight to Jamaica was relatively uneventful, other than a brief security concern in Salt Lake. Sometimes the purpose of our pilgrimage would surface, but most of our efforts were focused on making the necessary connections. Upon arrival in Montego Bay, we were met by Bunny, a new friend from a previous parent weekend and taxi operator extraordinaire from Treasure Beach. We piled our luggage into the rear compartment of his Toyota Station Wagon, Alicia took shotgun, and off we went on "Mr. Toad's Wild Ride." Four hours of too many cars, too little room, and too many potholes describes our third trip to Jamaica. Karyl and I were convinced that Jamaican vehicles were manufactured with overactive car horns, no brakes and an uncontrollable accelerator. Through the course of the trip Alicia's once proud fingernail collection had disappeared and Karyl had permanent fingerprints implanted in the back of Bunny's seat.

We arrived at Tranquility Bay, Caribbean Center for Change at 4:30 P.M. Our family visit with Carren wasn't scheduled to begin until the next day, but Bunny informed us that our family rep wanted to meet us prior to our reunion with Carren. We assumed that it was to establish the protocol for our visit, to set the ground rules, so to speak. We entered the reception area and received hugs and greetings from many of the staff members we had met on our October Parent Weekend.

We were visiting, discussing the eventful ride from Montego Bay to Treasure Beach, when the door from the pool area opened. Alicia, our oldest daughter and Scott, our 17-year-old son, had their backs to the door. They didn't notice who had entered. Only two feet away was the sister they hadn't seen for over a year. Karyl and I stood and watched, holding each other, tears running down our faces. It seemed forever before Carren's eyes adjusted to the interior light. She started to cry. Alicia and Scott turned around and once again our three children were together. They reached for each other at the same time. There were tears, and *I love you's* and *I miss you's* all at one time. Karyl and I held each other and cried. Once again they were sandbox buddies, queen bed acrobats, a trio of forest explorers with juice packs and chips. A miracle had happened; our family was beginning to heal.

We spent four magnificent days with Carren. There were many tears, challenges, and great love shared. The family disintegration that had occurred had not been pleasant and our time together was not always pleasant, but it was always respectful. We all shared our experiences and Carren apologized individually to each of us and each of us to her. Each day we would walk to a private beach, where the rising tide had erased our previous days activities. The sand was smooth and unmarred, reminding us that each day holds a new beginning. We each shared our fears, hurts and dreams. We were a family again.

It was not easy for us to send our daughter 3000 miles away from home to a foreign country where we had no control, and no personal experience. It was, however, the right choice for Carren and our family. She is proud of her accomplishments. We are proud of her. She admits it was tough and that early on she would have given up and walked away if she could have. Was it worth it? I think so. The morning we left, she whispered, "*Daddy? Thank you.*" I was holding my baby girl in my arms once again, both of us in tears.

Ron Clem
Kalispell, Montana
406-752-3703

Editor's note: Ron and Karyl Clem's daughter, Carren, is currently attending college and has earned a 4.0 GPA this semester.

Speaking Out:

a conversation with Mary Haydal

On November 21, 2000, we gave permission for the doctors to unhook the respirator that was keeping our 18-year-old daughter, Cassie, alive. Ten days before, Cassie had collapsed with a massive heart attack after returning from a rigorous two-hour basketball practice. She had been using meth.

We were numb. How could our honor roll student, journalist, poet, world-traveler, beautiful, happy daughter could be subject to drug addiction? She went to a country school and attended church on Sundays. We prayed together as a family. We knew her friends. We had opened our home to teens and had discussions with them that lasted hours at a time.

Children, teachers and parents showed up at our doorstep, in the hospital waiting room and at the funeral home to share their stories with us and to share their anger at Cassie's death. One teacher told me that if he had made a list of all the kids at the high school who used drugs, Cassie would have never been on it. What we didn't know was that methamphetamine had reached rural, middle-class America. Cassie's teachers didn't know. Her employers didn't know. Most of the parents didn't know. And the ones who did, didn't have a clue how to help. The more I read, researched and explored, the angrier I became. Reports show that if there is drug and alcohol in your child's environment, that child has a 50 percent chance of using.

We were seated around the dining room table one night with federal agents who were investigating Cassie's case when people started showing up at the door. Teens who used, teens who didn't even drink. Teachers. Law enforcement officers. I listened to them share conversation, and at one point I grabbed a pen and paper and started recording what was being said. The light went on . . . we had an epidemic in Miles City.

I have learned two things through my daughter's death: good people have addictions. I have the power to make change.

By chance, I started traveling and telling our story at schools all over southeastern Montana. In every town, I met family and friends of someone who had died because of meth. The epidemic had invaded our entire region. Gradually I learned that meth was an epidemic all over Montana.

On Cassie's death date, I was curled up in her room. I hadn't answered the phone all day, but for some reason, when the phone rang this time I picked it up. The voice on the other end was a mother who had lost her daughter to meth one week after we lost Cassie. Her daughter was beautiful. She had dreams of being a doctor, and yet one year after she started taking meth, she was in the correctional system. And then she killed herself.

When the phone rang again, I felt compelled to answer it. It was an ex-cop from L.A. He had retired in northern Montana. His daughter had used meth and unsuccessfully tried to commit suicide. They sent her to treatment. Ironically, while I was writing this she was graduating from her two-year treatment program. Her family graduated too.

The Meth Epidemic

The first reaction of all of us who loved Cassie was to point a finger. Why weren't law enforcement, the schools, the health care system *doing* anything? But teachers see addiction and don't know what it is. And then where do you report it? How do you know for sure, before you report it? Where do parents send their children to detox and dry out from the world's most addictive drug?

The answer took months to come. In Montana, we have few resources. Treatment may not be affordable or easily accessible for those who don't meet income criteria-specific, particularly those who are neither affluent nor living in poverty. The treatment that is available is not always age- or culturally appropriate. Not only that, but the schools I visited all over southeastern Montana had few resources. The teachers and school counselors had no videos, no training, no resource lists, no books. The Drug Task Force and Chemical Depen-

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This is your brain on meth

Long term methamphetamine abuse results in functional and molecular changes in the brain. Methamphetamine releases high levels of the neurotransmitter dopamine, which stimulates brain cells, enhancing mood and body movement. It also appears to have a neurotoxic effect, damaging brain cells that contain dopamine and serotonin. Over time, methamphetamine appears to cause reduced levels of dopamine, which can result in symptoms like those of Parkinson's disease, a severe movement disorder.

With chronic use, tolerance for methamphetamine can develop. In an effort to intensify the desired effects, users may take higher doses of the drug, take it more frequently, or change their method of drug intake. In some cases, abusers forego food and sleep while indulging in a form of binging known as a "run," injecting as much as a gram of the drug every 2 to 3 hours over several days until the user runs out of the drug or is too disorganized to continue. Chronic abuse can lead to psychotic behavior, characterized by intense paranoia, visual and auditory hallucinations, and out-of-control rages that can be coupled with extremely violent behavior.

National Institute on Drug Abuse InfoFacts. http://www.nida.nih.gov/Infofax/methamphetamine.html

Speaking Out

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dency Services of Southeastern Montana were short staffed, and both agencies were expected to cover 17 counties. The burnout rate was high and funding hadn't increased in years. How were they expected to be successful?

I spoke with administration, city officials, parents, teachers, school counselors, law enforcement officers, ministers, youth and ex-addicts. So many recognized there was a problem, and yet so few recognized the epidemic. They had no idea they could make a difference in their own communities.

The answer are here, among us. We can make a difference by empowering citizens, parents, law enforcement officers and other professionals by providing resources, enhancing services and increase funding.

Governor Martz and Attorney General McGrath put together the Alcohol, Tobacco, and Other Drug Policy Task Force in January 2002. The task was to define the need, suggest strategies and list the outcomes in a document that would become a blueprint for Montana with regard to dealing with tobacco, alcohol and other drugs.

I walked into that first meeting thinking that the primary concern for Montana was meth–related issues. But the team included representatives from MADD, DPHHS, exemplary treatment facilities, law enforcement, reservations, the judicial system, tavern owners, wholesalers and legislators. The next seven months were filled with grueling, intense research, discussion and brainstorming. On September 25, the *Living Document* for Montana was handed to Governor Martz and Attorney General McGrath.

As ordinary citizens, we have no idea how much power we have. We just have to believe we can make a difference. If you save one child, *you* are the hero! If you help one school or one church get resources, *you* are the hero! The definition of bravery is being scared and doing it anyway. As a citizen, parent and professional, here's what you can do:

1) Write to your Congressman and Legislators.
2) Get educated. There are some great web sites out there that are easy for laymen to understand.
3) Make sure your schools have drug information. Talk to teachers and counselors. Ask them what they need. A lot of information is free. You can find it on the web and order it.
4) If you love someone who is on drugs, get them help. Even if your child is 18, you can get guardianship over them until they are 21. You can get them into treatment.
5) Pray.
6) Share your stories with others. The more we share our stories, the less isolated families with this problem will feel.
7) Know that there is no religion, no socioeconomic group, no race that doesn't have children who use drugs. Everyone is looking the monster in the face.

—Mary Haydal is the Retired and Senior Volunteer Program Director in Miles City, and served as a member of the Governor's Alcohol, Tobacco and Other Drug Policy Task Force.

Medical complications

Methamphetamine can cause a variety of cardiovascular problems including rapid heart rate, irregular heartbeat, increased blood pressure, and irreversible, stroke producing damage to small blood vessels in the brain. Hyperthermia (elevated body temperature) and convulsions occur with methamphetamine overdoses, and if not treated immediately, can result in death.

Chronic methamphetamine abuse can result in inflammation of the heart lining, and among users who inject the drug, damaged blood vessels and skin abscesses. Methamphetamine abusers also can have episodes of violent behavior, paranoia, anxiety, confusion, and insomnia. Heavy users also show progressive social and occupational deterioration. Psychotic symptoms can persist for months or years after use has ceased.

Acute lead poisoning is another potential risk for methamphetamine abusers. A common method of illegal methamphetamine production uses lead acetate as a reagent. Production errors may therefore result in methamphetamine contaminated \with lead. There have been documented cases of acute lead poisoning in intravenous methamphetamine abusers.

NIDA: http://www.drugabuse.gov/ResearchReports/methamph/methamph4.html#medical

Adolescent Substance Abuse: A Major Public Health Problem

The Physician Leadership on National Drug Policy (PLNDP) recently released *Adolescent Substance Abuse: A Public Health Priority*, a comprehensive report on adolescent substance abuse. The report contains recommendations for policy changes aimed at the prevention, screening, assessment, and treatment of adolescents prone to or affected by abuse. It also highlights the link between adolescent substance use problems and mental health disorders, and explores the role that America's juvenile justice system can play in holding youth accountable while linking them to resources that treat addiction and prevent future problems. For more information, visit PLNDP's web site at *www.plndp.org*.

Dayminders

Project Common Vision Professionals Collaborating to Help At-Risk Children and Families

June 6-7, 2003—North Underground Lecture Hall, UM Campus, Missoula

For more information contact Amy Westereng, Program Coordinator Families First at http://www.missoula forum.org

12th Annual Montana Institute for Effective Teaching of American Indian Children

June 9-13—Bozeman, MT Museum of the Rockies

For more information contact: parsleyetc@aol.com *or see* http://www.opi.state.mt.us

A Community Approach to Unified Sentencing-Minors in Possesion

June 11-12—Holiday Inn, Hamilton, MT

For more information, contact Carol Stratemeyer at 406-363-4300 or by Email at: cstratemeyer@state.mt.us

MASCD Summer Institute 2003 "Instruction that Counts: Learning that Matters!"

June 17-19—Carroll College, Helena, MT

Summer Institute MBI 2003

June 16-20—MSU Boxeman

For more information, see http://*www.montana.edu/cs/mbi*

Methamphetamine Abuse

By Prakash Shet, MD, Psychiatrist, Montana State Hospital

Methamphetamine:

- goes by numerous street names including crystal, speed, crystal meth, crack, ecstasy and ice;
- is a powerfully addicting stimulant;
- is associated with serious health conditions including memory loss, aggression, psychotic behavior, potential heart and brain damage, and risk of HIV, Hepatitis B and C;
- is easily made in clandestine laboratories from readily available over-the-counter medications, which increases its potential for widespread abuse.

The first report of amphetamine psychosis appeared in 1938, and the first epidemic began in the late 1960s. At this point, the abuse of methamphetamines is once again an extremely serious and growing problem. Although amphetamines are used legitimately for the treatment of narcolepsy and attention-deficit hyperactivity disorder, the National Household Survey on Drug Abuse (2000) found that 4 percent of the population (approximately 8.8 million people) reported lifetime non-medical use of stimulants. The Drug Abuse Warning Network reported a 30 percent increase in methamphetamine-related episodes in major metropolitan areas between 1999 and 2000.

Effects and administration

Methamphetamines can be swallowed, injected, snorted or inhaled. The half-life of amphetamine ranges from 7 to 19 hours; that of methamphetamine is slightly longer. Methamphetamines have potent mood-elevating and euphorigenic effects. In many cases, use results in addiction, a chronic relapsing disease characterized by compulsive drug-seeking and drug use, as well as functional and molecular changes in the brain. The release of dopamine in the limbic system leads to the reinforcing and mood-elevating effects of methamphetamines, but the dopamine can break down into highly toxic chemicals that damage nerve cells. In fact, research in animals has revealed that as much as 50 percent of the dopamine producing cells in the brain can be damaged with long term exposure to low doses of methamphetamine.

Psychiatric syndromes

The clinical effects of methamphetamine use depend on the dose, route of administration and pattern of use. With low doses, behavior may seem to be within normal limits. With higher doses, there is hyperactivity, restlessness, teeth grinding, hyper talkativeness, irritability, short-tempered behavior, decreased sleep, decreased appetite and weight loss. With very high doses, behavior and judgment can be severely disrupted and the likelihood of developing toxic paranoid states is very high.

Persistent use can cause a number of psychiatric disorders including psychosis, intoxication delirium, mood, anxiety or sleep disorders and sexual dysfunction. Methamphetamine-induced psychosis can be indistinguishable from schizophrenia and may require psychiatric hospitalization for stabilization of symptoms. This psychosis may resolve spontaneously after a few days or may require treatment with antipsychotic medications. Typically, psychotic symptoms remit within a week, but in a small percentage of cases, psychosis may last for a month. Methamphetamine induced mood disorder may present with manic or depressive symptoms. At times, it may be difficult to differentiate from a primary mood disorder, especially in people with chronic use.

Treatment

Some studies reveal a mortality rate for amphetamine users 11 times higher than that of the general population. There are no specific treatments for methamphetamine dependence, and most casual users do not seek treatment. Those with moderately severe dependence seek treatment in a variety of outpatient programs that are not designed specifically to treat methamphetamine dependence. Some of the most severe cases may end up in the criminal justice system or psychiatric hospitals. A wide variety of pharmacological agents have been tried without success in treating methamphetamine dependence. The most effective treatments at this time are cognitive behavioral interventions. These approaches are designed to help modify the patient's thinking and behavior and to increase the coping skills necessary to deal with various life stressors. Support groups also are effective adjuncts to behavioral interventions that can lead to long-term drug free recovery.

—See related article, page 22.

Profile of a Hero: *Nikki Pearson*

Babies who have been severely neglected don't cry. Children who have survived a home where a parent is addicted to methamphetamine know hunger, fear and severe neglect. No one cares whether or not they stay clean or safe—no one cares whether there's soap or clean clothes or food in the house. These children have knowledge far beyond their years, and they've become independent far beyond their years because they've had to. Once this addiction sets in, parents lose focus on everything but the drug.

Nikki Pearson is a full time adult probation and parole officer, and has been for eight years. She's also been a full-time foster parent for the past two and a half years. During that time, she's had 28 foster children. Between her job and her vocation, she's had a bird's eye view of the impact of methamphetamine on two of our most important systems. She says that she is seeing more women than ever before on probation and parole, and that it's largely because of methamphetamine. This insidious drug pulls mothers away from their children long before social services can step in to take the children. Sometimes grandparents are able to care for them, sometimes they wind up in foster care. If they're lucky, they end up in Nikki's home—or another that's just as stable and loving.

The whole idea behind foster care is to help ensure that families have the opportunity to heal and reunite. Nikki says it's incredibly rewarding to see mothers pulling their lives together. And it does happen: if anything is going to serve as the final straw, push women into getting help, it is losing their kids. But Nikki knows that while the majority of parents will get their children back, many won't. Once this drug takes over in the role of primary relationship, there is precious little room for anything—or anyone—else.

In Nikki's experience, many of these women had normal lives, were holding jobs and caring for their families until they started to dabble in methamphetamine, but normal can take the long slide into hell in a very short time with this drug. The truth is, not one of these women thought they'd wind up in trouble with drugs, much less in prison. And what finally lands them there may not be a drug-related offense at all—they can just as easily be arrested for writing bad checks, shoplifting or burglary. But these offenses often boil down to the fact that people will do whatever it takes to get the money to buy the drug. Although prison isn't the optimum treatment choice, it can carry a silver lining: the methamphetamine addicts who have the best chance of success are completely removed from the scene of abuse for two years.

When children land on Nikki Pearson's doorstep, she never knows how long they'll stay. It could be a few days—a few months—or years. She takes children between the ages of 0–10 and immediately plugs them into her world, where days are orderly and highly structured. Nikki has learned that routine is the best medicine for these children: it makes them feel safe. Learning that their days can be predictable is a luxury many have never experienced. It takes anywhere from ten days to two weeks before she can begin to see the routine work its magic. Some kids hide food, and she says that watching them stop is one of the most rewarding moments of fostering children. Another is watching them learn the language they need to describe their feelings . . . opening up . . . or just reaching for a hug. One child came to her when he was 14 months old. He'd never really been out of his crib, much less had the opportunity to move around. He'd certainly never walked—and now—at almost 2—he's running . . . *everywhere*.

Nikki will be the first to tell you that she doesn't do it alone. She says that the social workers are wonderful, that Head Start and public school teachers go the extra mile, and that the therapists she's come into contact with are exceptional. The Department of Family Services provides wonderful training and support. Everyone is willing to work with parents to help them learn parenting skills, to connect them with the many services available at the community level, to help them mend their lives.

Nikki has a three-year-old right now. He's been with her for months, and every night like clockwork he looks up at her and asks, "Breakfast?" And every night like clockwork she hugs him and says, "Yes. You had breakfast today and you will have breakfast tomorrow . . . I promise."

– It was my privilege to interview Nikki Pearson for this article. Sherrie Downing, Editor

Prenatal Exposure to Meth

Preliminary findings indicate that methamphetamine use is associated with growth restriction in infants born at term. Additionally, withdrawal symptoms requiring pharmacologic intervention were observed in 4 percent of methamphetamine-exposed infants. The study "Effects of prenatal methamphetamine exposure on fetal growth and drug withdrawal symptoms in infants born at term" appears in the Journal of Developmental and Behavioral Pediatrics 2003;24(1):17-23).

Statistics compiled by the Montana Department of Public Health and Human Services show that a significant number of Montanans are seeking treatment from state-approved chemical dependency programs for methamphetamine addiction. In 1995, 15 percent of the people treated in these programs used methamphetamine; by 2001, that number had increased to 26 percent.
http://www.doj.state.mt.us/enforcement/drugenforcement.asp

Montana's Comprehensive Anti-Meth Effort

"Meth is a devastating drug. Individuals, families and communities are hurting as a result, and this one-time source of funds will support enforcement, prevention and early intervention efforts never before possible in this state."

—Mike Batista, Administrator of Montana's Division of Criminal Investigation

Using federal COPS (Community Oriented Policing Services) funds, the Montana Department of Justice is implementing the first stages of a long-term, comprehensive effort to impact the illicit production, distribution and use of methamphetamine.

The number of illegal meth production labs uncovered in Montana has already set new records with more than 150 labs in 2002. *"Drug lab seizures and new arrests take place almost every day,"* says Batista.

Planning for a coordinated anti-meth campaign began last spring with the announcement of availability of COPS funds for use in Montana. Throughout the summer, law enforcement officers, researchers, prevention specialists and drug treatment professionals collaborated with Attorney General Mike McGrath to come up with a project plan suitable for federal funding.

The resulting project initiative authorizes the acquisition of specialized enforcement equipment, overtime for law enforcement officers investigating clandestine meth production labs, improvements at the state crime lab, new computer resources and a sustained public education—early intervention program. While new enforcement efforts have already commenced, many of the details for prevention/intervention efforts will be worked out during strategy sessions that will take place throughout 2003. Increased methamphetamine reduction efforts are expected to last for two years.

"In the next few months," said Batista, "more than 30 tribal, state and local law enforcement officers will be selected to complete a series of specialized training courses conducted at training facilities within the Cascade County Sheriff's Office in Great Falls and the Law Enforcement Academy in Helena."

Officers will be trained and certified to instruct short courses for safety response personnel and the public. Under the COPS-funded plan, there will be new programs for police, fire and emergency medical personnel called to respond to clandestine labs. Anti-meth training will be offered to parents, citizen groups, property owners, hospital staff and other citizens and professionals who may encounter individuals addicted to this powerful, unpredictable drug.

New training programs will meet standards established as a result of Montana's recent inclusion in the Rocky Mountain High Intensity Drug Trafficking Area (HIDTA). A special effort is underway to increase enforcement of child endangerment statutes and placement efforts necessary to protect children put at risk by the filth, neglect and hazardous conditions associated with methamphetamine addiction. In fact, according to statistics collected in several western states, 32% of all children removed from homes where drugs have been manufactured, possessed or abused test positive for methamphetamine.

In Montana, COPS funds will be used to sponsor statewide training about drug endangered children. The first step is aimed at creating an alliance between individuals charged with protecting and caring for kids being harmed by meth. Ten Montanans representing law enforcement, social services, medical professions and criminal justice prosecution attended the 1st Annual Utah Drug Endangered Children Conference in Salt Lake City on March. This group will plan how the information can be used to bring about improvements in Montana.

Along with efforts directed towards drug endangered children, a rural initiative is being planned as a means of providing education and support to Montana farmers and ranchers. The theft of anhydrous ammonia and other farm chemicals used to produce methamphetamine, as well as significant damage to agricultural equipment and facilities, occurs when clandestine drug labs are set up in isolated rural areas. Rural residents will be provided with tips for securing at-risk property and reporting suspicious circumstances. Radio announcements will be broadcast in conjunction with the spring planting season.

For Batista, federal funds have been made available at a time when state funding for investigation and enforcement has been reduced. "COPS and HIDTA funds are a blessing," he says, "and will finally allow us to address a serious drug epidemic that before, could only be addressed on a piecemeal basis."

—For more information regarding meth or the DOJ Initiative, contact Mike Batista, Administrator, Division of Criminal Investigation 444-3874 or mbatista@state.mt.us

Editor's note: Mike McGrath and Mike Batista deserve credit for developing the DOJ Initiative and for the work completed thus far. They have worked hard to garner resource and bring recognition to the problem.

Please see pages 14-15 of this issue for more information on this initiative.

Meth Labs and Rats

By Frederick J. Cowie, Ph.D.

Many years ago, my brother had a rat problem. Rats were coming up from an adjacent piece of land into his yard. He had little kids, lots of them as I remember. My brother called the health department, which sent a man out.

The man said, "Mister, the world is full of rats. We can't get rid of the rats, but we can get the rats out of your yard. Now, don't worry where the rats go, because, like I said, the world is full of rats and we can't get rid of the rats. Now, do you want to get rid of the rats in your yard?"

Well, my brother happened to be coming from a very smart set of kids himself, and he said that of *course* he wanted to get rid of the rats in his yard.

"Okay," said the man from the health department, "the rats are in your yard because it's easy to live here—they're eating your pet food. Make life inhospitable. Get rid of the food. Make their life hard. They will go find some other sucker to give them food. That's all they want—an easy life."

Soon, my brother had no rat problem. Where did they go? He didn't care.

Methamphetamine LAB: Local Alliance Building

Methamphetamine can take over a small rural town like gunslingers used to take over cow towns in the old westerns. And just like in the movies, townspeople have to band together, build a local alliance against meth, and take back their town. This is not easy, but this is not about easy. It is about our children, their children, our way of life.

It's time local Montanans get their heads out of the proverbial sand to say, "Let's clean up this meth!"

We, as local citizens, need to band together. It may take a village to raise a child, but it takes a local alliance to get rid of meth labs in a town or a county. We have to muster our hometown pride and address the problem. We have to channel the spirit that backs local teams and channel it to beat meth labs. It won't be easy, but few things worth fighting for are. The solution won't be simple, because the problem isn't simple, but as far as I can see, it's a rat problem.

As a free, democratic, open society, we honor civil rights, we honor freedom, we honor independence. Unfortunately, that leaves lots of room for concomitant problems, problems allowed to grow because we don't want to infringe upon American freedoms. We have made it easy, too easy, for methamphetamine to slip into our culture.

Back to meth labs and rats

Meth labs are full of hazardous chemicals: acids and bases, toxic gases, flammable liquids. Fortunately, we have developed good protocols for dealing with such things. Some thirty years of hazardous materials (hazmat) legislation has given America a fairly good handle on response to hazardous materials incidents. It has taken a long time and lots of hard work, but we have broken down adversarial relationships between the public health and response organizations on one hand, and the producers, transporters and retailers of hazardous materials on the other. Now fire fighters, law enforcement officers and EMS personnel stand side-by-side with the friendly local hazard providers to manage and watch over the cleanup of truck spills, railroad accidents and fixed-site incidents. As communities, we have developed local protocols and alliances to deal with hazmat incidents. Now we must broaden this concept, open new avenues of communication, work with ongoing investigations, crime scenes, and evidence chains. We must—as towns and counties—deal with hazmat and "rats."

The crisis is here

Why are clandestine meth labs in your town? Simple: it's easy, easier than some other town! How do we make it less easy? Simple: make it harder to set up meth labs! How do we make it harder? Here are some suggestions.

— Advertise that your town/county is getting "tough on meth."

— Set up communication systems whereby citizens can report suspicious activities to appropriate authorities who will follow up and work with citizen groups, and who will make sure that feedback occurs.

Continued on Page 10

Local alliances can:

— *Identify high risk user groups and develop education, mentoring, counseling initiatives*

— *List the chemicals used to make meth and the local sources of those chemicals*

— *Work with retailers owners to monitor sales of precursor chemicals, equipment*

— *Work with anhydrous ammonia tank owners on security and notification issues*

— *Work with schools and parents to help identify the behavioral signs of meth use*

— *Work with health care personnel to identify the neurological and health problems of meth users and secondary victims*

— *Set up health care systems to work with the secondary health victims of meth use: children, the elderly, the disabled*

— *Work with landlord and motel owner groups on facility rehab and public health issues*

— *Develop checklists of signs that a meth lab is around or that a group is a meth "cell"*

— *Develop a local system whereby law enforcement can easily and anonymously be notified that a residence or building is being used as a meth lab or for meth sales*

— *Develop adult mentoring, peer mentoring, after school programs*

By Dr. Fred Cowie

The Great Falls Alliance

By Mary E. Fay

Methamphetamine—use and labs—are ravaging our community, as they are in many, if not most, Montana communities. Methamphetamine affects the physical, mental and emotional health of the user and the children who are exposed. Labs contaminate sites that include motel/hotel rooms and rented apartments. There are major environmental impacts on our water supplies. And then there's the financial drain on local and state coffers caused by clean-up, increased crime, treatment programs, law-enforcement and prison beds.

Great Falls Mayor Randy Gray is leading the way in finding solutions to critical problems caused by the increasing use of methamphetamines in the Great Falls community. To this end, he has organized a working committee of community activists who are committed to finding solutions. The committee made up of four district court judges, four legislators (who are also a deputy county attorney and a juvenile probation officer), the sheriff, the chief of police, the city court judge, two justices of the peace, directors and counselors of two treatment programs, adult probation and parole personnel, a criminal defense attorney, the Guardian Ad Litem program and the director of the Adult Pre-Release center.

At the request of Mayor Gray, and with the support of this committee, Senator Trudi Schmidt (D-Great Falls) agreed to sponsor Senate Joint Resolution No. 11. This resolution reads "to request a study the problems of alcohol and drug abuse and of prevention, early intervention and treatment." This study will be carried out by an interim committee and all aspects of the study will be presented to the 2005 legislative body. This interim committee will serve as the vehicle for implementing the Governor's Alcohol, Tobacco and Other Drug Policy Task Force recommendations, which were provided in the task force's *Blueprint for the Future.* The Bill has become law, and was filed with the Secretary of State April 11.

The community of Great Falls plans to charge ahead to find effective solutions to the methamphetamine scourge. This working group will continue to look for innovative and effective solutions for successfully preventing methamphetamine use, for early intervention and for longer term treatment.

—Mary Fay retired in December 2002 as the Bureau Chief for the Probation & Parole Bureau, Department of Corrections. She served as a member of the Treatment Subcommittee of the Governor's Alcohol, Tobacco and Other Drug Policy Task Force.

Great Falls Mayor Randy Gray formed a community work group after reading a U.S. Department of Justice Bulletin, Practitioner Perspectives: "Wyoming's Methamphetamine Initiative: The Power of Informed Process" *by David Singh, May 2001. The article can be found online at* www.ncjrs.org/pdffiles1/bja/186266.pdf.

Interestingly, this article also provided direction to the Governor's 2002 Alcohol, Tobacco and Other Drug Control Policy Task Force. The complete Comprehensive Blueprint for the Future the final document of the work of the task force is available on-line at www.discoveringmontana.com:/gov2/css/drugcontrol/default.asp

Meth Labs and Rats

Continued from Page 9

— Train organizations (e.g., YMCA, Kiwanis, Girl and Boy Scouts, Neighborhood Watch), retailers (hardware stores, department stores, drug stores) and service providers (utilities, cable and satellite installers, delivery services) about the outward signs of a meth lab, the precursor chemicals used in production and meth/hazmat safety awareness.

— Have standard reporting checklists, so that law enforcement officers get usable data.

— Disrupt the illegal, clandestine meth lab activity.

— Use confiscatory authority to take the means of meth production, transportation and sale away from the people running meth labs.

Ignorance, non-action and indifference make things easy for the "rats" to move in and set up meth labs. If you make it hard, they will take their explosive, toxic meth production sites elsewhere. Unfortunately, dealing with meth labs and running them out of town might be the easier part of the job. Dealing with the personal and social effects of methamphetamine use will take a broader alliance and more intense level of cooperation and coordination. But, then again, no one said this will be easy.

Dr. Cowie is a versatile trainer, facilitator and writer with an expertise in Hazmat issues. He can be reached at fredcowie@aol.com.

A Great Resource:

Wyoming Launches Most Comprehensive Anti-Drug Plan in U.S..

http://www.jointogether.org/sa/news/features/reader/0,1854,555304,00.html

A Meth Lab May be Present . . .

— Unusual, strong odors (like cat urine, ether, ammonia, acetone or other chemicals).
— Residences with windows blacked out.
— Renters who pay their landlords in cash. (Most drug dealers trade exclusively in cash.)
— Lots of traffic - people coming and going at unusual times. There may be little traffic during the day, but at night the activity increases dramatically.
— Excessive trash including such items as: antifreeze containers, lantern fuel cans, red chemically stained coffee filters, drain cleaner, duct tape and large amounts of glass.
— Unusual amounts of clear glass containers being brought into the home.

From kci.org/meth_info/links.htm

Agricultural dealers should:

— Inform employees and customers about the theft problem.
— Store nurse tanks in well-lighted areas.
— Inspect tanks every morning.
— Block driveways with a gate or barricade.

Growers should:

— Require delivery of tanks to the farm as close to the time of actual application as possible.
— Position tanks in open areas where they can be seen from the roadway by passing motorists and law enforcement officials.
— Discourage temporary storage of nurse tanks in buildings or near the farmhouse or livestock.
— Inspect tanks upon delivery, and every day thereafter for signs of tampering.
— Use tank locks and/or tamper tags, remove hoses from the applicator to the tank.
— Stay aware, report suspicious activity immediately.

According to the Agricultural Retailers Association (Nov 2000), in regards to Anhydrous Ammonia,

Anhydrous Ammonia TANKLOCK – Farmland Industries, Inc.
Dodge Manufacturing Division
dodgeandco.com – 1-888-862-7550

Meth Labs in Montana

Drug Enforcement Agency statistics on the number of methamphetamine labs that required removal of hazardous materials by a specialized contractor and the expense to taxpayers of cleaning up the labs (by federal fiscal year, Oct. 1 - Sept. 30).

Year	# of Labs	Taxpayer Expense
1999	16	$98,000
2000	33	$235,000
2001	86	$631,000
2002	122	$1,005,000

In recent years, Montana has seen a substantial increase in the local production of methamphetamine by small, but dangerous clandestine labs that can be assembled in apartments, hotel rooms, cars, camper trailers and outdoors. The toxic waste these labs generate poses significant risks to public health and safety risks. The cost of removing the contaminants from these sites has also increased substantially over the past few years.

Source: Montana Department of Justice, *http://www.doj.state.mt.us/enforcement/drugenforcement.asp*

Clandestine Meth Labs

Five or six pounds of toxic waste are produced for each pound of crank manufactured. Leftover chemicals and toxic by-products are often poured down drains in plumbing, storm drains, or even directly onto the ground, and can remain in the soil and groundwater for years. Clandestine labs are considered hazardous waste sites and the cost of cleaning one up site can range from $5,000 to as much as $150,000. *http://www.montana.edu/wwwai/imsd/rezmeth/*

Possible indications of the presence of a math lab:

Alcohol
Ether
Benzene
Toluene/Paint Thinner
Freon
Acetone
Chloroform
Camp Stove Fuel/Coleman Fuel
Starting Fluid
Anhydrous Ammonia
"Heet"
White Gasoline
Phenyl-2-Propane
Phenylacetone
Phenylpropanolamine
Iodine Crystals
Red Phosphorous
Black Iodine
Lye (Red Devil Lye)
Drano Muriatic/Hydrochloric Acid
Battery Acid/Sulfuric Acid
Epsom Salts
Batteries/Lithium
Sodium Metal
Wooden Matches
Propane Cylinders
Hot Plates
Ephedrine (over-the-counter)
Cold Tablets
Bronchodialators
Energy Boosters
Rock Salt
Diet Aids

From kci.org/meth_info/links.htm

For more information, contact:

Montana Department of Justice
Mike Batista, DCI Administrator
Division of Criminal Investigation
P.O. Box 201417
COPS Methamphetamine Initiative
Helena, Montana 59620-1417
(406) 444-3874

2002 COPS Methamphetamine Initiative: Mont

Enforcement

Intelligence Analyst

Equipment

Overtime

Case Management Software

Crime Lab Equipment

Project Administration

Attorney General
Mike McGrath 444-2026

Division of Criminal Investigation
Mike Batista 444-2967
Loraine Shepard 444-3158
Greg Noose 444-2013

Prevention - Intervention

MOST of Us®

Encouraging local voices raised against meth in accordance with a comprehensive MTDOJ game plan

HIDTA Training

Providing an accredited, coordinated program of anti-meth training delivered by police
— law enforcement / public safety first responder training
— citizens / commnity coalitions awareness training - action planning

Conferencing for Communities

Informing and empowering key community stakeholders from throughout Montana who will take a strong stand against meth

Drug Endangered Children

Acting to protect Montana kids who are forced to live in hazardous drug-impacted environments

Lowering the bar for charging meth-related child endangerment

Rural Initiative

Supporting Montana farmers, ranchers and isolated rural communities

Bridge Program

Providing new or enhanced treatment and support to Montana mothers and dependent children adversely affected by meth

Big Brothers Big Sisters

Reaching at-risk youth through support for mentoring, training and anti-meth messages delivered through traditional and school based BBBS programs

tana Residents Responding to the Crisis of Meth

— Design an effective anti-meth campaign
— Create a permanent framework to address newly developing threats to public safety

Research	New materials
Survey methods	Coordinated schedules
Consultation	Scripts - speaking points
Planning	Web sites
Technical support	Spamming

Red Ribbon Week
October 18 - 26, 2003

Coordination with the Montana Office of Public Instruction

Clan Lab Safety Certification Course
May 19 - 23, 2003

HIDTA Train the Trainer Aug. 18 - 19, 2003
Ithica . . . Decision Making Aug. 20, 2003
Drug Symptomology / Identification
Aug. 21 - 22, 2003

Instructor Cadre

Creating a *Montana Alliance*

Human Beings!!
Data and Information
Outreach Clearinghouse

Conference in Great Falls, MT Oct. 1 - 2, 2003

Six - Eight Town Meetings
Mini Sessions

Ten Montana Representatives @ *Utah DEC Conference*
March 27-28, 2003

Montana DEC Planning Meeting
April 2003

Conference Track
Great Falls
October 2003

2003 Planting Season

- Protecting anhydrous and other farm chemicals
- Increased reporting and awareness

Partnership established via MOU between MTDOJ and MT DPHHS

Project now underway

Helping those who "go the distance"
Big Brothers Big Sisters of Montana
9 local chapters of Big Brothers Big Sisters
MT Sheriffs and Peace Officers Association
Smith and McGowan, Inc. applying for other grants

A new statewide coordinator

Coordinating with OPI

Project Contacts

MOST of US®
Jeff Linkenbach 994-3837

HIDTA Training
Greg Noose 444-2013
Tamara Lazarte (303) 671-2180

Conferencing
Fred Cowie 431-3531

Drug Endangered Children
Greg Noose 444-2013
Fred Cowie 431-3531

Rural Initiative
The Mitchell Group
Doug Mitchell 449-7303

Bridge Program
Matt Dale 444-1907

Big Brothers Big Sisters
Annette Leeland 222-1930

Slang for Methamphetamine

— **Methamphetamine:** beannies, black beauty; black; blade; blue meth; boo; chalk; chicken feed, cinnamon, clear, cr, crank; crink, cris, Cristina, crossles, crypto; crystal; croak; crystal meth; fast; geep; geeter; getgo; go fast; granulated orange; ice; jet fuel; load of laundry; lemon drop; Methlies Quik; motorcycle crack; nazimeth; ozs; pink; pink hearts; quill; redneck cocaine; rock; schmiz; scootie; shabu; sketch; spackle; sparkle; soap dope; speckled birds; speed; spoosh; stove top; tick tick; Tina; trash; wash; water; white cross; work; working man's cocaine; yellow bam; yellow powder

— **Smokable methamphetamine**: batu; Cristy; hanyak; hironpon; hiropon; hot ice; kaksonjae; L.A.; glass; ice; quartz; super ice

— **Bathtub crank:** poor quality methamphetamine; methamphetamine produced in bathtubs

— **Bikers coffee:** methamphetamine & coffee

— **Box labs**: small, mobile, clandestine labs used to produce methamphetamine

— **Christmas or holiday meth**: green methamphetamine produced using Drano crystals

— **Cooker**: to inject a drug; person who manufactures methamphetamine

— **Glass**: heroin; amphetamine; hypodermic needle; methamphetamine

— **Crank craters:** sores on the face caused by meth

— **Crankster**: someone who uses or manufatures methamphetamine

— **Crush & rush:** method of methamphetamine production in which starch is not filtered out of the ephedrine or pseudoephedrine tablets.

— **Crystal glass:** crystal shards of methamphetamine

— **Dropping:** wrapping methamphetamine in bread and then consuming it

— **Eightball**: eighth of an ounce = 3.5 grams

— **Elbow:** one pound of methamphetamine

— **Fire:** crack & methamphetamine; to inject a drug

— **Five-way:** combines snorting of heroin, cocaine, methamphetamine, ground up flunitrazepam pills, and drinking alcohol

— **Gangster**:person who uses or manufactures methamphetamine

— **Hot rolling:** liquefying methamphetamine in an eye dropper, then inhaling it

— **Hugs & kisses** or **Super X:** combination of methamphetamine & MDMA

— **Medical supplies or utensils:** paraphernalia

— **Meth head:** methamphetamine regular user

— **Meth monster**: one who has a violent reaction to methamphetamine

— **Meth speed ball**: methamphetamine combined with heroin

— **Points, rigs, slammers:** needles

— **Paper**: a dosage unit of heroin; one-tenth of a gram or less of the drug ice or methamphetamine

— **Red:** under the influence of drugs; methamphetamine

— **Speed freak**: habitual user of methamphetamine

— **Speedballing:** the simultaneous use of a stimulant with a depressant

— **Superlab**: clandestine laboratories capable of producing 10 pounds of methamphetamine in 24 hours

— **Tina**: methamphetamine; methamphetamine used with Viagra

— **Teena** or Tina: name derived from the fact that meth is commonly bought in sixteenths of an ounce packages (AKA "baggies")

— **Tooter**: the straw used to snort the drug

— **Tweek:** methamphetamine-like substance

— **Ya ba:** a pure and powerful form of methamphetamine from Thailand; "crazy drug"

http://www.whitehousedrugpolicy.gov/streetterms/

The cycle of abuse

Rush: the initial response the abuser feels when using methamphetamine. The abuser's heartbeat races and metabolism, blood pressure, and pulse soar. Unlike the rush associated with crack cocaine, which lasts for approximately 2 - 5 minutes, the methamphetamine rush can continue for 5-30 minutes.

High—the rush is followed by the high, sometimes called the "shoulder." During the high, the abuser often becomes argumentative, often interrupting other people and finishing their sentences. The high can last 4-16 hours.

Binge—the binge is the continuation of the high. The abuser maintains the high by smoking or injecting more methamphetamine. Each time the abuser smokes or injects more of the drug, a smaller euphoric rush than the initial rush is experienced until, finally, there is no rush and no high. During the binge, the abuser becomes hyperactive both mentally and physically. The binge can last 3-15 days.

Tweaking—tweaking occurs at the end of the binge when nothing the abuser does will take away the feeling of emptiness and dysphoria, including taking more methamphetamine. Tweaking is the most dangerous stage of the methamphetamine abuse cycle. If the abuser is using alcohol to ease the discomfort, the threat to law enforcement officers intensifies.

Crash—an incredible amount of sleep. The body's epinephrine has been depleted, and the body uses the "crash" to replenish its supply. Even the meanest, most violent abuser becomes almost lifeless during the crash and poses a threat to no one. The crash can last 1-3 days.

Normal—after the crash, the abuser returns to "normal"—a state deteriorated from the one before s/he used methamphetamine. This stage ordinarily lasts between 2 and 14 days. However, as the frequency of binging increases, the duration of the normal stage decreases.

Withdrawal—no acute, immediate symptoms of physical distress are evident with methamphetamine withdrawal, a stage that the abuser may slowly enter. Often 30-90 days pass after the last drug use before the abuser realizes that he is in withdrawal. First, without really noticing, the individual becomes depressed and loses the ability to experience pleasure. The individual becomes lethargic; he has no energy. Then the craving for more methamphetamine hits, and the abuser often becomes suicidal. These feelings end when the abuser takes methamphetamine, contributing to the difficulty in finding models for successful rehabilitation.

http://www.stopaddiction.com/drugpages/methamphetamine_addiction.html

Drug Endangered Children

By Phyllis MacMillan, AMDD

Few people realize the devastation to children living in homes where methamphetamine is manufactured, distributed or used. Last year in Butte County, California, parents of a three-year-old girl rushed her into a hospital emergency room; over the weeks that followed it was unclear if she would live or die. She lived.

"Beth's" parents were meth "*cooks*," so toxic chemicals were present throughout the home. One summer afternoon, the child was thirsty, but couldn't get either parent's attention. Her mother was sleeping off a meth binge; her father, sitting on the sofa in a drugged haze. Beth found a jar beneath a cabinet with pink liquid in it and as she climbed up next to her dad, she began to drink. She started screaming as the liquid ran down her throat and onto her chest. The toxic chemical burning down her throat was eating away her esophagus and stomach. The liquid that spilled down Beth's front ate through her chest wall. Today, Beth lives on life support systems, but will never eat. She is fed through a tube into her intestines. She will never go to school, have children or do any of the other things we all hope for our children.

Last October, California police officer Sue Webber-Brown presented information at the Indian Child and Family Conference in Great Falls about the Drug Endangered Children (DEC) Response Teams she started in 1991. Sue told the audience about a four-month-old child who died because the caregiver had been putting the pacifier in the same ashtray where the crank pipe was kept. This home was not a meth lab, but the residue left after smoking meth is still toxic enough to kill a child. In another recent California case, a mother has been charged with murder in the death of her four-month-old child—she used meth while nursing.

Webber-Brown provided a graphic slide presentation depicting the conditions and dangers present in meth homes. We've all seen pictures of law enforcement personnel busting meth labs, dressed in protective suits complete with breathing masks. But how many of us have stopped to imagine *children* living and eating there, with no protection at all? One set of parents wore protective masks and industrial strength gloves while they cooked meth, telling the children that they were making gasoline for the truck. The children had *no* protection and were barefoot, one, in a diaper, was crawling around on the floor.

The US Department of Justice, Drug Enforcement Agency estimates that 35 percent of children present at meth labs will test positive for toxic levels of chemicals. In Montana, the Department of Justice Division of Criminal Investigation (DCI) estimates more than 170 meth labs will be busted in the state in 2003—that approximately 65 will have children in them and that more than 100 children will be affected in all.

Efforts are now underway to establish meth alliances in Montana communities. This problem will require the involvement of entire communities if we are to succeed in slowing the devastation to children whose caregivers are addicted to methamphetamine. The Drug Endangered Children Program will require law enforcement agencies, child protection workers and medical personnel, school teachers and counselors, children's advocacy groups and chemical dependency treatment professionals to work together in support of these children. These children need them all.

—For further information regarding Montana's Meth Initiative, contact Mike Batista (mbatista@state.mt.us) or Greg Noose (gnoose@state.mt.us) at the Division of Criminal Investigation or (406) 444-3874 .

Free Video

To obtain a free video of Sue Webber-Brown's Montana DEC presentation, contact: Phyllis MacMillan at (406) 444-7044 or by e-mail at pmacmillan@state.mt.us

Who belongs in a local alliance?

— *Atypical meth lab responders: law enforcement officers, fire department personnel, EMS providers*

— *A typical future responder who doesn't enter the hazmat scene: child and adult protective services*

— *Prosecutors and meth-use property confiscation personnel*

— *Group home program personnel (for recovering victims and children)*

— *Treatment and recovery personnel*

— *Medical personnel (besides ems providers above): pediatrician, emergency room, school nurses*

— *School officials, counselors and teachers*

— *Local community organizations with kids' programs (BB&S, YMCA, etc.)*

— *Local groups who see things (e.g., hunters, utility workers, cable/ satellite installers)*

By Fred Cowie, Ph.D.

METH-FREE MONTANA

By Jeffrey Linkenbach, Ph.D.

"MOST OF US will never encounter the drug methamphetamine, but it affects us all."

This statement is the primary building block that Montana's top law enforcement administrator, Attorney General Mike McGrath, would like to use in methamphetamine prevention campaigns across our state. In addition to conducting research and providing technical assistance to the Montana Department of Justice Methamphetamine project, Montana State University's MOST OF US™ research team is developing a strategic communications plan and key speaking points for the Montana AG's methamphetamine prevention project, METH-FREE MT.

It is important for prevention organizations to have well-designed strategic communications plans. This defines a problem and its solutions. When it comes to communicating about health problems like those resulting from methamphetamine use, the press often constructs a "frame" defining and describing social health problems and their solutions. This frame, in turn, shapes or structures public conversations and perceptions. Often the media will convey a crisis-focused message highlighting extreme behaviors that do not convey an accurate picture of the problem. The problem with this traditional approach is that it can actually have the negative effect of amplifying and reinforcing misperceptions of the true context of the problem.

McGrath realized that the best approach for Montana is to avoid spreading unnecessary fear and concern about methamphetamine. What is needed is the development of a proactive, consistent speaking framework—one that defines the Montana methamphetamine problem, its solutions and specific prevention actions in a way that results in mobilizing and empowering community efforts without distorting perceptions of the true prevalence. Research consistently demonstrates that realigning misperceptions of social norms through media and other interventions can result in improved health behavior. Adapting and working from the positive framework of the social norms model is at the heart of the METH-FREE MT communications strategy.

In order to accomplish the goal of clear, consistent communications, a web site is being developed at the domain of *www.METHFREEMT.ORG*. This comprehensive site will seek to serve the unique needs of our Montana communities. Targeted materials will be developed for the agricultural community, parents, landlords and others. The following draft of key speaking points will serve as a guide for framing the communications around METH-FREE MT, including the development of media, conference materials, training events, press releases and more.

Each of the five key speaking points in the sidebar at the left include specific points that are undergoing revisions with the help of a statewide advisory group and key stakeholders. In this way, we can all be sure that, all across our state, we have a single, unified voice about the vision of a METH-FREE MT.

Speaking Points for METH-FREE MT

The following five key topic areas have been established and speaking points are being developed in each area though a process involving key stakeholders.

1. Scope—*Most of us in Montana will never encounter meth, but it affects us all.*

2. Effects—*This drug is potentially more devastating than any other because of its wide-ranging impacts on users, the economy, community, the environment, children and families.*

3. Join Together—*This drug is unusual in that we all can actually play a role in stopping its use and production. The solution to this problem comes when each of us takes up our role and together we form a powerful coalition.*

4. Solutions—*There are many simple things that we can do as we go about our daily lives to ensure that each Montanan knows how to help and how to get help.*

5. Meth-Free MT—*Montana was meth-free before and it can be again.* Meth-Free MT *is the program that makes creating a meth-free Montana achievable.*

Signs of Meth Labs

Unusually strong odors such as ether, ammonia acetone or other chemicals, residences with blacked-out windows, lots of traffic with people coming and going at unusual times, and excessive trash, including large amounts of fuel cans, red chemically stained coffee filters, drain cleaners and duct tape. Lab owners usually bring large quantities of glass into their homes and since most drug dealers trade in cash, most renters will pay their landlords in cash. http://www. montana. edu/wwwai/imsd/rezmeth/

Treatment: *Dialectical Behavior Therapy and Substance Abuse*

By Michele McKinnie, Psy.D.

Early findings offer hope that Dialectical Behavior Therapy (DBT) will be an effective treatment approach for severe behavioral difficulties associated with substance abuse and dependence. Several research projects have been conducted to study the use of DBT in treating drug dependent women with Borderline Personality Disorder (BPD). A pilot application using an extension of the standard DBT approach was used with methamphetamine dependent women with BPD in year 2000[1]. The primary goal was to eliminate substance abuse and dependence and other dysfunctional behaviors while increasing behavioral control through the use of functional, skillful behavior. Findings from this and other studies[2] suggest that DBT *is* effective in decreasing self-harm, including serious drug dependence. It is also useful in helping maintain treatment participation and compliance, as well as abstinence over time. While methamphetamine abuse and dependence are extremely difficult to treat effectively, the results of these studies provide grounds for optimism.

DBT is an empirically supported, behavioral treatment for chronically suicidal and parasuicidal individuals who meet diagnostic criteria for BPD or have Borderline traits. A significant percentage of individuals with BPD have problems with substance abuse[5]. At the same time, behaviors common to Borderline Personality Disorder are similar to behaviors seen in individuals who abuse or depend on substances. These include impulsive behaviors, suicidal and self-harm ideation, chronic feelings of emptiness, and difficulties regulating emotional distress. The overlap of behavioral symptoms between BPD and substance abuse/dependence is significant.

Initial treatment techniques include weekly individual psychotherapy and group skills training, skills coaching, telephone consultation, and regular meetings of the team of therapists. My professional experience with individuals who are abusing or dependent on methamphetamine or other drugs has been limited to a handful of cases, most of whom meet criteria for BPD or show numerous Borderline traits.

Anecdotal data from my work in an inpatient setting has been generally positive. As a therapist working with these notoriously difficult clients, I have found DBT to be a valuable tool. DBT skills have helped patients find alternative methods of managing severe emotional distress or difficult situations. These individuals made significant early gains in decreasing severe self-harm behaviors and suicidal thoughts, and reported feelings of increasing self-worth and self-efficacy, even in challenging situations.

– Michele McKinnie, Psy.D. is a licensed psychologist in private practice in Bozeman. Correspondence may be addressed to her at 612 East Main St., Suite B, Bozeman, MT 59715

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DBT

DBT was developed by Marsha Linehan, Ph.D. and her colleagues at the University of Washington in Seattle, a team of researchers and clinicians dedicated to "compassionate, scientifically valid treatments made available to every person with complex and severe mental disorders." (*Behavioral Technology Transfer Group*)

From the Comprehensive Blueprint for the Future: a Living Document by the Governor's Task Force on Alcohol, Tobacco and Other Drug Abuse Policy, page 42:

For 2001, the Montana Department of Health and Human Services' special report on alcohol and drugs reported that out of 8,365 admissions in state-approved programs for alcohol and drugs, 1,530 of those admissions, or 18 percent, were for methamphetamine. A further break-down of the admissions include:

- *2920 female admission, 620 for meth;*
- *512 Native American females, 126 for meth;*
- *5,455 male admissions, 910 for meth; and*
- *844 Native American male admissions, 137 for meth.*

The Center for Substance Abuse and Treatment funded a Methamphetamine Treatment Project. in seven sites in three states. Assessment characteristics of clients starting treatment revealed that the meth users in Billings had the highest rate of intravenous drug use at 56 percent.

http://www.discoveringmontana.com/gov2/content/drugcontrol/FINAL_ATOD_Task_Force_Report.pdf

Mother's and Children's Recovery Homes: *Family Habilitation*

See pages 19-21 to learn more about the Mother's and Children's Recovery Homes.

Montana has three recovery homes specifically designed to treat women and their children. The women participating must have a diagnosis of substance dependency and must either be pregnant or have dependent children. The three recovery homes are:

1. The Carol Graham Home in Missoula;
2. Michel's House in Billings; and
3. Gateway Group Home in Great Falls.

Goal: To provide the opportunity for women and their children to participate in a comprehensive system of care that maximizes long-term physical, emotional, and social health, self-reliance, and family habilitation.

Children up to the age of 12 live with their mothers; older children are included in treatment, but do not live at the recovery home. All three homes provide individualized, comprehensive care that promotes health and self-sufficiency. This is accomplished by providing stable housing, a safe environment, opportunities to build personal and parental skills, good nutrition and a balance of work, school, appropriate play and leisure activities.

Women pay rent of $200 per month. They are responsible for cleaning common and family areas, grocery shopping, meal preparation, laundry, attending individual and group treatment sessions, caring for their children and learning new parenting skills and child care principles. This is often the first experience these women have with a safe, nurturing – "normal" – family environment.

Two of these homes began working on this project with the Chemical Dependency Bureau on July 1, 2002 and one on October 1, early indications are that they will be very successful.

When these women came to the recovery homes:

— 89 percent were unemployed

— 42 percent were homeless

— 9 percent were pregnant

— 97 percent had been diagnosed with mental health issues

— 42 percent had significant medical issues

— 82 percent had a diagnosis of methamphetamine abuse or dependency

— 70 percent had a diagnosis of alcohol abuse or dependency

— 55 percent had a diagnosis of poly-substance abuse or dependency illness, meaning that the individual uses three or more drugs

— 45 percent were IV drug users

Success stories

The typical length of stay is about a year. Among recent "graduates," one earned a Certified Nurses' Assistant (CNA) and began pursuing an RN; one earned an Associates Degree; one achieved her GED; and one is currently a supervisor in a large facility.

The outcomes of this program are very positive. Families are reunited. Mothers achieve sobriety. Children receive the care and treatment they need. Mothers begin to learn the skills they need to care for their children and themselves. Untimately, the chances are very good that this type of treatment will break destructive inter-generational patterns.

BEFORE	AFTER
Employed: 11%	Employed: 52%
Average education: 11th grade	34% working toward degree or certification
Facing legal charges other than child neglect/abuse: 33%	Arrest free: 85%
Facing child neglect/abuse charges: 67%	Family reunified: 48%

The Carole A. Graham Home

By Peg Shea, Executive Director

Fully 90% of the women admitted to the Carol A. Graham Home last year identified methamphetamine and alcohol as their drugs of choice.

In the not-so-distant past, neither addicted women with children nor their referral sources had many choices when considering treatment programs. Often unemployed, the client was unable to afford costs associated with as little as 12 hours of treatment a week. Out of necessity, the Carol A. Graham Home opened in Missoula to address this need.

The goal of this unique program is to serve addicted women who meet specific criteria. They must have a primary diagnosis of chemical dependency, be pregnant or have custody of their children at least 51% of the time, be TANIF eligible and in need of residential care.

This program was developed as an effort, often of last resort, to keep families together and to interrupt the cycle of addiction. The women who come to the Carole A. Graham Home have often lost custody of their children or have open Child and Family Services cases. Programming at the home allows the women to maintain custody while engaging in services that address their addiction and deficit living skills.

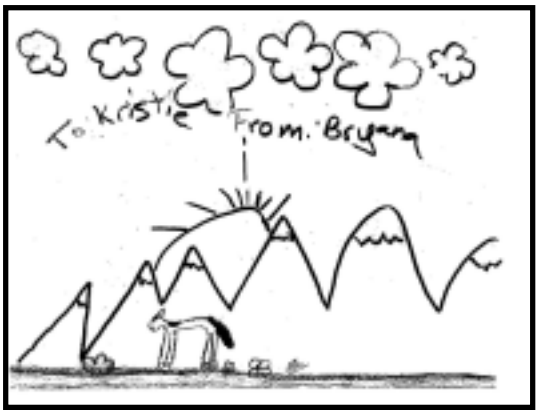
Statistically, children who have an addicted parent are four times as likely to develop an addiction themselves. The ideology of the Carol A. Graham Home is to get the addicted mother into a place of wellness while building life skills that will assist them in breaking the cycle of addiction with their own children.

By a child staying at the Carole A. Graham Home. She thought the home was *safe like angels*.

The mothers who come into the program often do not know how to care for the most basic needs of their children. They do not have the skills needed to properly address a child's nutritional, medical or emotional demands. The programming at the Carol A. Graham Home allows for intensive case management of the client, while incorporating skill development that enhances their ability to function as healthy parents.

The average client at the Carol A. Graham Home will stay six months before transitioning into the community. During their stay, employment, educational, parenting and life skills have been redefined, allowing them to maintain long-term sobriety.

When a resident achieves her goals in the Carol A. Graham home, she often realize for the fist time that she can accomplish things she had not even dared dream about. As one former resident stated, " *If I can do this then I can do anything I choose to for myself and my kids, as long as I stay sober*." This, in essence is what this program is all about.



By a child who got to have horseback riding lessons while in the Carole A. Graham Home.

The greatest part of recovery for me is my children. They share with me, trust me, and respect me for what I am doing. Maybe someday they don't have to be in fear; I pray someday that will happen. There is no one, no place, or thing that would make me want to relive the last few years. I never want to see that look on my daughters' faces like I saw 15 months ago.

I hope and pray that everyone that comes to the Home will learn to love themselves enough to want to live a sober life . . . I hope I have broken the chain so that my children and my grandchildren will never have to turn to alcohol, drugs or abusive relationships.

– a resident of the Gateway Recovery Center

PNA Data Bites

http://oraweb.hhs.state.mt.us:9999/prev_index.htm

In the 2002 Prevention Needs Assessment, 2.4 percent of Montana's youth between the ages of 12-17 reported using methamphetamine or other stimulants within the past 30 days. This survey is administered bi-annually to youth in grades 8, 10 and 12. The data reveals that the usage rate among reporting youth is down by 14.29 percent since year 2000, but still reflects use among 2,119 of Montana's youth.

For more information, contact Pete W. Surdock, Jr., M.S.W., ACSW, Project Director at 444-3964 or by e-mail at psurdock@state.mt.us

Who *Says* Treatment is Not Prevention?

By Mona Sumner, Executive Director

Michel's House, located in Billings and operated by Rimrock Foundation, is in its second year of operation. Moms and their children live in individual apartments and attend day treatment at Rimrock Foundation for as long as the women need the services. We work closely with the Yellowstone Family Drug Court and have the benefit of Dr. Brenda Roche's services in providing neuro-psych evaluations on our moms and their children. This has also been the evaluation process used for the drug court. With the benefit of the neuro-psych evaluations on the families, we have learned a great deal more about child neglect.

At present, our children range in age from infants to age ten. Our infants exhibit classic developmental delays that you might expect if you are familiar with child neglect. We are finding it relatively easy to catch these babies up with assistance from the Early Childhood Intervention Team. What we knew less about however, it's that each of our pre-school and elementary school children have expressive language disorders.

One little guy wrote on his Christmas card to his mom, "I love having you home every night and I never want us to leave Michel's House."

These children are so deficient in vocabularies and language that they cannot adequately express themselves or their feelings. This is generally true of neglected children and it occurs because addict parents do not talk to their children—let alone play or interact with them and read to them.

Language cannot be learned by young children except by intimate interaction with parents. Without significant intervention, these children will continue to have serious language deficiencies that research shows will lead to the development of disruptive behavior disorders by the time they reach adolescence.

We have taken the position that one of the most important prevention challenges we have is to aggressively respond to these children's language deficiencies in the hope of preventing serious adolescent behavior problems. We do this by contracting with each mom to read to her child no less than 20 minutes a day and, in the case of older children, to listen to the child read for at least 10 minutes a day as well. We work with each mom to spend an additional 30 minutes in nurturing and bonding activities including having a bedtime ritual for each child that makes sleep easy and pleasant. We are grateful to the Bridge Program (see page 22) for making some funds available for use to begin a library of age appropriate books for each child.

Our moms begin a parenting curriculum after the initial 90 days of treatment designed just for addict-moms. Our apartments each have posters "of the many faces of feelings." We work with moms to teach their children a new feeling word each day. They use the posters to help their children express themselves. If a child cannot talk out feelings, s/he will act them out in negative and hurtful ways—many of our moms remind us they need this same help because as the children of addicts, most were neglected themselves.

Our kids benefit from the security, consistency and safety of Michel's House and will tell you—as they have told us—that they never want to leave. We take comfort in knowing that when they do, they will have gathered the skills they need to succeed.

Treatment and Parity

A significant barrier to appropriate chemical treatment is the fact that health plans and third party payers typically provide far less coverage for substance abuse treatment than for other medical services. Montana's "Mandated Benefit Law" (MCA 33-22-703) provides minimum coverage for chemical dependency in- and outpatient treatment. It is *not* on parity with other disease coverage and is not sufficient to cover all treatment costs.

Comprehensive Blueprint for the Future: a Living Document by the Governor's Task Force on Alcohol, Tobacco and Other Drug Abuse Policy, page 48.

http://www.discoveringmontana.com/gov2/content/drugcontrol/FINAL_ATOD_Task_Force_Report.pdf

Gateway Recovery Home

By Judy Kolar, Director

The Gateway Recovery Home provides a structured, supportive, chemical-free residential environment for women undergoing treatment services. The Home was opened by the Gateway Recovery Center in 1997, and in the interim, the program has grown and changed in accordance with the severity of needs among residents.

We have observed a gradual increase in the mental health needs of our residents, partially due to the current methamphetamine crisis in our community. At this point, 84 percent of our residents are attempting to recover from methamphetamine use. This is consistent with a recent survey by AMDD that included all three of Montana's women's recovery homes. That survey revealed that 82 percent of the residents of these homes were either experiencing methamphetamine dependency or abuse. This has increased the need for mental health services during chemical dependency treatment and the time it takes a woman to begin functioning independently. The women who have custody of their children also find it much more difficult to deal with them, which in turn increases the need for staffing and staff education. We expect these problems to multiply as the methamphetamine crisis in our community continues.

At this point, only women who are pregnant and/or have dependent children are eligible for the program. If the children are not currently in the resident's custody, a reunification plan is defined, and women work on that plan while residing with us. Most of the women we see are eligible for Medicaid and TANF services. These benefits help our residents meet their financial needs while they focus on treatment issues and relationship building with their children.

In its six years of operation, the Gateway Recovery Home has served 168 women and their children. The average length of stay for those who complete programming is 175 days (5 months), although four residents have resided with us for over a year. When a woman and/or her children arrive, a biopsychosocial assessment is offered off-site. This is used to identify the overall needs of each resident and her children. Afterward, services are individualized to meet the specific needs of each resident.

Life skills development is a priority need for this population. Goals focus on relationships, employment/finance, relapse prevention, nutrition, and social skills. Residents also have daily experience in building problem resolution skills as they work with other residents and staff in a community setting.

Outcome measurements are based on increased knowledge and achievement of the resident's life skills plan, and are measured quarterly. FY02 data was extremely hopeful. During their stay:

— 78 percent of the residents remained abstinent from mood altering chemicals;

— 86 percent gained employment;

— 83 percent maintained an individualized budget; and

— 55 percent achieved their educational goals.

Primary funding has always been from the Addictive and Mental Disorders Division. As a community, Great Falls has also been very supportive, which has meant that the program can offer a very strong community-based network of services. On an annual basis, we have also been supported by the United Way of Cascade County and other local grant foundations have been very generous in assisting our program.

—For further information, contact Linda Blankenship, Recovery Home Manager at 452-6655.

PNA Data Bites

http://oraweb.hhs.state.mt.us:9999/prev_index.htm

Among the 2.4 percent of Montana students who reported using methamphetamine or other stimulants within the past 30 days:

— *39% were 12th graders, 38% were 10th graders, and 23% were 8th graders;*

— *55% reported using 1-2 times;*

— *19% reported using 3-5 times;*

— *13% reported using 6-9 times;*

— *7% reported using 10-19 times;*

— *3% reported using 20-39 times; and*

— *3% reported using 40 times or more.*

For more information, contact Pete W. Surdock, Jr., M.S.W., ACSW, Project Director at 444-3964 or by e-mail at psurdock@state.mt.us

The Bridge Program

When the State of Montana was awarded a special federal Community Oriented Policing grant, it was Attorney General Mike McGrath's priority to ensure that a portion of the funding be used to directly serve recovering users of methamphetamine and their children. The Bridge Program increases the range of options for methamphetamine prevention and intervention and recognizes that mothers in recovery experience financial difficulties that can impede that recovery. The Bridge Program helps close the gap between recovery needs and existing resources.

Perhaps the most important aspect of the Bridge Program is fostering the bond between parent and child. For mothers and children to succeed in leaving their addictive past, they must be a strong and cohesive unit.

Mothers recovering from addiction have to meet many requirements to live in a recovery home with their children. While there, typical expenses include transportation to treatment and daycare, clothing for graduation or job interviews, and emergency assistance for unexpected living expenses. The Bridge Program supports eligible expenses specific to ensuring that the mother has every chance of achieving success in her efforts to end her addiction.

The Bridge Program also helps address the special medical, educational, social and family needs of the children of addicted mothers. Assistance in one of these areas often flows into another. Expensive neurological testing is available to determine whether or not a child has experienced lasting effects from living in a methamphetamine environment.

While many children residing in the Women's Recovery Homes have some form of medical insurance, it usually won't cover the kind of specialized testing they need. The results from this testing are also useful in determining whether the child has special educational needs. This is particularly important because when children have rewarding learning experiences, they stand a better chance of breaking the trans-generational cycle of addiction.

Other eligible expenses support activities that encourage bonding and may include tutoring, clothing, school supplies, and parental tools including books for the mom to read to her children.

Bridge Program funding is available for mothers and children living in one of three women's recovery homes. To be eligible for this assistance, the mother must be committed to following recovery home guidelines, to successfully ending her addiction, and to the overall health of her children. An additional percentage of funding will focus on the specific needs of the children, most of which are not readily affordable in a mother's small household budget.

The Bridge Program was implemented the end of February 2003. In the short time since our services have become available, we have received 47 applications from recovering mothers and their dependent children. It is our goal to provide quality, life-improving financial assistance to recovering mothers and their children.

For more information, contact Michelle Truax at 444-3728.

MNA Update

—This summer MNA intends to offer group health insurance coverage as part of its member services programs.

The Montana Nonprofit Association (MNA) is a statewide association of 501(c)(3) nonprofit organizations. MNA's mission is to strengthen the leadership, skills, effectiveness, and efficiency of Montana's nonprofits and enabling them to further enrich the quality of community and personal life in Montana.

To learn more about MNA, contact bigskyin@mt.net or call Mike Schechtman at 406-443-5860; Joy McGrath at 406-442-2218; or Gary Owen at 406-727-3400.

Meth at MSH

By Nici Wallis RN, C

Approximately 60 percent of admissions to Montana State Hospital last year received some type of drug or alcohol diagnosis. The reality could be much higher. Clients with methamphetamine use are admitted to MSH due to the symptoms they display, including physical agitation, transient visual, tactile, or auditory hallucinations or illusions. They may also display a profound sense of euphoria followed by depression and fatigue. Damage to the brain can be observed in brain scans and can persist months after usage stops. Depressive mood and/or drug-related impairment of cognitive functioning can occur. Many of the chronic users have poor dentition, experience malnourishment and skin sores. Agitation can be high during intoxication.

Given the many symptoms that can occur, it can be difficult to come up with a diagnosis at the time of admission. Methamphetamine use can produce symptoms that mimic many severe mental illnesses and treatment is based on symptoms. Antipsychotic drugs may be used for the first few days to treat paranoid or delusional symptoms, antidepressants for a month or longer for the depression. Benzodiazepines may be used to decrease agitation. Based on the acuity of this population, MSH must provide a greater intensity of observation to ensure the safety and well-being of the client. This includes a highly structured milieu, medication management, group and individual therapy. Sometimes it even means one-to-one patient:staff ratios.

Even after the client has been stabilized, risk assessments are ongoing because of such issues as suicidal ideation and risk of violence to others. Not all hospitals can manage clients who exhibit the extremely violent behaviors seen in the "meth" abuser. I believe as this problem continues to grow in the communities an increase number of admissions will be seen at MSH as result.

Meth in Rural Montana

By Carol Stratemeyer, Chief Juvenile Probation Officer, Judicial District #21

– Meth labs have replaced "grow operations" in Ravalli County.

—Ravalli County Undersheriff Kevin McConnell

Kari Jo first came to the attention of the 21st Judicial District Youth Court when she was 15 and cited for drinking while underage—twice in less than a week. By the time she was 16, she had added another alcohol violation to her juvenile record. A bright, pretty girl, Kari Jo had a promising future if she could have gotten her chemical abuse under control. Instead, a few days after her 18th birthday, Kari Jo died from a lethal concoction of alcohol and drugs in a dingy, run-down drug house in rural Darby, Montana. Kari Jo just stopped breathing. The other drug users in the house were oblivious to her death because of their own drug-induced stupor.

The manufacture and use of methamphetamine in the small towns of Ravalli County is astronomical compared with what it was just a few years ago. In the first three months of 2003, three drug labs have been raided. This is compared with a total of seven since 2000. According to Undersheriff Kevin McConnell, Ravalli County is a prime area for meth labs due to a lack of resources and because it's an easy link to Missoula and Spokane, Washington. In Sheriff Chris Hoffman's estimate, another 10 to 14 labs are expected to be discovered by the end of the year. Overdose deaths are also increasingly common. Kari Jo was one of one of four in the past year. Along with another teen and an adult male, Kari Jo's death was the third in just the last six months.

Teen involvement with meth has skyrocketed as evidenced by several positive drug screens for youth in the juvenile justice system. As a condition of probation, all youth are required to consent to regular drug screening. Along with marijuana, methamphetamine tests were added two years ago to detect early experimentation. Due to the fact that meth is detectable in urinalysis for only a short time, no youth tested positive the first year. Last year, six youth tested positive. Another three positive tests were taken at the Ravalli County Detention Center.

Overdose is not the only serious social problem caused by increased chemical use by youth. Last summer, several burglaries and two separate crimes of church desecration in the Bitterroot Valley were directly attributed to meth use. Two 16-year old boys were involved in the burglaries of several homes. Both had good backgrounds, solid school records and no previous criminal involvement. That one crime spree by these two boys netted several thousand dollars in cash and merchandise as well as senseless vandalism of prominent homes—homes that at least one of the boys had been a guest in. The boys claimed that most of the $4,000 that they took in cash was used for meth and other drugs.

Compounding the growing meth problem is that Ravalli County is one of the two fastest growing areas in Montana and one of the fastest growing areas in the nation. In the past decade, the Bitterroot Valley increased by 40 percent. While the population has increased, the local law enforcement and court system has not increased at the same growth rate. Sheriff Hoffman said that one drug officer is responsible for the entire valley—an area that stretches from just south of Missoula to the Idaho border. Added to the vast geographical area, there are six school districts in seven rural communities. According to Hoffman, the Ravalli County Sheriff's Department could add three more drug officers and still not have enough to combat the increase in drug lab activity.

Great Resources

Join Together Online
http://www.jointogether.org/home/

Tips for Teens: The Truth about Methamphetamine
National Clearinghouse for Drug & Alcohol Information
http://www.health.org/govpubs/PHD861/

Montana Department of Justice
Drug Enforcement
http://www.doj.state.mt.us/enforcement/drugenforcement.asp

Kalispell Police Department
Stop Meth
http://www.stopmeth.com/

The California Department of Justice
The Meth Crisis
http://www.stopdrugs.org/methcrisis.html

HBO Documentaries
Crank: Made in America
http://www.hbo.com/docs/programs/crank/

The Koch Crime Institute Website
FAQs About Methamphetamine
http://www.kci.org/meth_info/faq_meth.htm

The Alcohol and Drug Information Clearinghouse
Looking for a good resource near you?
http://www.prevlink.org/referral/states/montana.html

Mind Over Matter
Drug resources for working with kids in grades 5-9
http://www.nida.nih.gov/MOM/MOMIndex.html

The Great Falls Tribune
"Locals Decry Mounting Costs"
An excellent story by Kim Skornogoski, March 16, 2003
http://www.greatfallstribune.com/news/stories/20030316/localnews/1188033.html

The Long Journey into Light

By Roland M. Mena, Administrator, Chemical Dependency Bureau

Stigma: "a mark of shame or discredit."
– Webster's Dictionary

Addiction is often viewed as a mark of shame, and shame destroys hope, breeds secrecy, creates censure. These conditions make it difficult to differentiate illness from crime. Unfortunately, stigma is intensified by relapse, which is, in itself, a predictable part of this disease. And while there is no question that the public must be protected from the crimes rising from methamphetamine addiction, the people who struggle with this disease deserve an opportunity for treatment, an opportunity to get well.

Best case scenario, people enter recovery and eventually come out transformed by personal, emotional and behavioral change. Although every addict's experience with recovery will be unique, there are five *Stages of Change* that addicts typically pass through on their way to lifetime recovery:

1. Pre-contemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

Unfortunately, treatment is not one-size-fits-all. Addiction is complicated. Environmental, economic, gender- and age-based factors need to be considered in determining the best course of treatment. If all of these variables aren't factored in to prescribing appropriate treatment, we can end up setting people up to fail. Treatment must be holistic and those working with methamphetamine addiction need to establish treatment plans specifically geared to the issues rising from use of this drug.

The key to effective treatment is to meet the individual's stage of change. By engaging people in the healing process, providing opportunities for skill development, we can engender hope. And hope is absolutely vital to the recovery process.

Recovering from an addiction to methamphetamine can be a particularly long and arduous journey that seems longer still because the damage caused by this drug makes it impossible for the recovering addict to feel interest, pleasure or joy. Perhaps the most important thing to remember is that treatment is a long-term process, not an event. Addiction doesn't develop overnight, and people don't recover in a single step. But treatment of the right kind, at the right time, and in the right amount works. There *is* hope.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

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MONTANA Department of Public Health & Human Services

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Montana Prevention Resource Center
P.O. Box 4210
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